

**COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL HEALTH**

**Application For Care And Treatment On A Conditional Voluntary Basis
M.G.L. Chapter 123, Sections 10 & 11**

Name of Patient (please print) _____

Address: _____ City/Town _____ State _____

Social Security Number: _____ Date of Birth: _____ Sex M ☐ F ☐

To the Superintendent (or other head) of _____
Name of Facility

1. I am 16 years of age or older and hereby apply to be a patient at the above facility.
2. I realize that when I want to leave the facility, I must give written notice to the Superintendent of the facility, who may delay my departure for up to three days (excluding Saturday, Sunday and holidays).
3. Once I give notice of my intention to leave the facility, I realize that if the Superintendent thinks I might be a danger to myself or other people because of my mental illness, he or she may petition the District Court within the three-day period seeking to have me committed to (ordered to stay at) the facility for up to six months. The Court will schedule a hearing. I have a right to be represented by an attorney at the hearing. If I cannot afford an attorney, the Court will appoint one for me. After the filing of the petition, the Court has five (5) business days to begin a hearing on my commitment. During this time, I must remain at the facility. At the hearing, the judge will decide whether or not I can leave the facility.
4. I realize that if the Superintendent thinks I need to have a legal guardian with special authority to consent to my staying at the facility, he or she may petition the Probate Court to hold a hearing. However, he or she may not delay my departure unless an order allowing such a delay is issued by a Probate Court judge before the end of the third day (excluding Saturday, Sunday and holidays) after I give notice.
5. I agree to receive treatment at this facility for my mental illness. I understand that this agreement does not limit my right to refuse at any time specific treatment interventions such as antipsychotic medication, electroconvulsive therapy or psychosurgery.
6. I have been given a copy of my Notice of Rights (Form CV-301).
7. I have been offered the opportunity to consult with a lawyer or paralegal concerning the effect of a conditional voluntary admission.
8. I understand that the facility will accept or reject this application in accordance with the applicable clinical and legal standards.

Signature of Patient

Date

Witness

Date

ACCEPTANCE/REJECTION BY THE FACILITY

The following questions shall be answered, and the application shall be accepted or rejected, by a designated physician* of the facility.

1. This patient

- | | Yes | No |
|---|--------------------------|--------------------------|
| A. has been diagnosed with mental illness, as defined in 104 CMR 27.05 (1), | <input type="checkbox"/> | <input type="checkbox"/> |
| B. is in need of care and treatment for this mental illness, | <input type="checkbox"/> | <input type="checkbox"/> |
| C. is in need of hospitalization (i) for such care and treatment <u>or</u> (ii) to prevent serious harm due to the absence of a more appropriate placement alternative. | <input type="checkbox"/> | <input type="checkbox"/> |

2. This facility is suitable for such care and treatment.

☐ ☐

3. I have determined that this patient understands that he/she

- | | | |
|--|--------------------------|--------------------------|
| A. is agreeing to stay and receive treatment at this facility, | <input type="checkbox"/> | <input type="checkbox"/> |
| B. must sign a three-day notice of his/her intention to leave, | <input type="checkbox"/> | <input type="checkbox"/> |
| C. may or may not be allowed to leave without a court hearing. | <input type="checkbox"/> | <input type="checkbox"/> |

If every box is checked "Yes", then the application shall be accepted unless the patient has not yet been admitted, in which case the application may be accepted only if the facility's criteria for admission have been met. If any box is checked "No", the application shall be rejected, unless only boxes "1.A", "1.B.", or "2" are checked "No" and the patient's continued voluntary hospitalization is necessary to prevent serious harm due to the absence of a more appropriate placement alternative.

The patient may not sign a three-day notice until this form has been accepted.

I, a designated physician* of this facility, hereby (check all applicable boxes):

4. ☐ **Accept** this application for conditional voluntary hospitalization:

- ☐ A. Patient is applying for admission and all criteria for admission are met.
- ☐ B. Only boxes "1.A", "1.B" or "2" are checked "No" and continued hospitalization is necessary to prevent serious harm due to the absence of a more appropriate placement alternative.

5. ☐ **Reject** this application for conditional voluntary hospitalization. Reasons:

Designated Physician's Signature

Date

Printed Name

Title

This patient's competency to remain on Conditional Voluntary status must be reassessed at the time of each periodic review.

FILE IN PATIENT'S RECORD IMMEDIATELY

* A physician who meets the criteria in 104 CMR 33.03